APPENDIX C

REQUIRED FORMS

FOR

REQUEST FOR PROPOSALS (RFP)

APPENDIX C
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REQUIRED FORMS

EXHIBITS

REQUIRED FORMS - EXHIBIT 1

PROPOSER'S ORGANIZATION QUESTIONNAIRE/AFFIDAVIT

Please complete, date and sign this form and place it as the first page of your proposal. The person signing the form must be authorized to sign on behalf of the Proposer and to bind the applicant in a Contract.

1. If your firm is a corporation or limited liability company (LLC), state its legal name (as found in your Articles of Incorporation) and State of incorporation:

_____ _____ _____
Name State Year Inc.

2. If your firm is a limited partnership or a sole proprietorship, state the name of the proprietor or managing partner:

_____

3. If your firm is doing business under one or more DBA's, please list all DBA's and the County(s) of registration:

Name	County of Registration	Year became DBA
_____	_____	_____
_____	_____	_____

4. Is your firm wholly or majority owned by, or a subsidiary of, another firm? ____ If yes,

Name of parent firm: _____

State of incorporation or registration of parent firm: _____

5. Please list any other names your firm has done business as within the last five (5) years.

Name	Year of Name Change
_____	_____
_____	_____

6. Indicate if your firm is involved in any pending acquisition/merger, including the associated company name. If not applicable, so indicate below.

_____

_____

Proposer has provided documentation and acknowledges and certifies that it meets and complies with the Minimum Mandatory Qualifications as stated in Paragraph 3.0, of this Request for Proposal.

Check the appropriate boxes:

☐ **Yes** ☐ **No** _____ years experience, within the last ___ years

Proposer further acknowledges that if any false, misleading, incomplete, or deceptively unresponsive statements in connection with this proposal are made, the proposal may be rejected. The evaluation and determination in this area shall be at the Director's sole judgment and his/her judgment shall be final.

Proposer's Name:

_____

Address:

_____

_____

E-mail address:_____ Telephone number:_____

Fax number: _____

On behalf of _____ (Proposer's name), I _____ (Name of Proposer's authorized representative), certify that the information contained in this Proposer's Organization Questionnaire/Affidavit is true and correct to the best of my information and belief.

_____	_____
Signature	Internal Revenue Service Employer Identification Number
_____	_____
Title	California Business License Number
_____	_____
Date	County WebVen Number

REQUIRED FORMS - EXHIBIT 2

PROSPECTIVE CONTRACTOR REFERENCES

Contractor's Name:_____

List Five (5) References where the same or similar scope of services were provided in order to meet the Minimum Requirements stated in this solicitation.

1. Name of Firm	**Address of Firm**	**Contact Person**	**Telephone #** ( )	**Fax #** ( )
Name or Contract No.	# of Years / Term of Contract		Type of Service	Dollar Amt.
2. Name of Firm	**Address of Firm**	**Contact Person**	**Telephone #** ( )	**Fax #** ( )
Name or Contract No.	# of Years / Term of Contract		Type of Service	Dollar Amt.
3. Name of Firm	**Address of Firm**	**Contact Person**	**Telephone #** ( )	**Fax #** ( )
Name or Contract No.	# of Years / Term of Contract		Type of Service	Dollar Amt.
4. Name of Firm	**Address of Firm**	**Contact Person**	**Telephone #** ( )	**Fax #** ( )
Name or Contract No.	# of Years / Term of Contract		Type of Service	Dollar Amt.
5. Name of Firm	**Address of Firm**	**Contact Person**	**Telephone #** ( )	**Fax #** ( )
Name or Contract No.	# of Years / Term of Contract		Type of Service	Dollar Amt.

REQUIRED FORMS - EXHIBIT 3

PROSPECTIVE CONTRACTOR LIST OF CONTRACTS

Contractor's Name:_____

List of all public entities for which the Contractor has provided service within the last three (3) years. Use additional sheets if necessary.

1. Name of Firm	**Address of Firm**	**Contact Person**	**Telephone #** ( )	**Fax #** ( )
Name or Contract No.	# of Years / Term of Contract		Type of Service	Dollar Amt.
2. Name of Firm	**Address of Firm**	**Contact Person**	**Telephone #** ( )	**Fax #** ( )
Name or Contract No.	# of Years / Term of Contract		Type of Service	Dollar Amt.
3. Name of Firm	**Address of Firm**	**Contact Person**	**Telephone #** ( )	**Fax #** ( )
Name or Contract No.	# of Years / Term of Contract		Type of Service	Dollar Amt.
4. Name of Firm	**Address of Firm**	**Contact Person**	**Telephone #** ( )	**Fax #** ( )
Name or Contract No.	# of Years / Term of Contract		Type of Service	Dollar Amt.
5. Name of Firm	**Address of Firm**	**Contact Person**	**Telephone #** ( )	**Fax #** ( )
Name or Contract No.	# of Years / Term of Contract		Type of Service	Dollar Amt.

REQUIRED FORMS - EXHIBIT 4

PROSPECTIVE CONTRACTOR LIST OF TERMINATED CONTRACTS

Contractor's Name:_____

List of all contracts that have been terminated within the past three (3) years.

1. Name of Firm	**Address of Firm**	**Contact Person**	**Telephone #** ( )	**Fax #** ( )
Name or Contract No.	Reason for Termination:			
2. Name of Firm	**Address of Firm**	**Contact Person**	**Telephone #** ( )	**Fax #** ( )
Name or Contract No.	Reason for Termination:			
3. Name of Firm	**Address of Firm**	**Contact Person**	**Telephone #** ( )	**Fax #** ( )
Name or Contract No.	Reason for Termination:			
4. Name of Firm	**Address of Firm**	**Contact Person**	**Telephone #** ( )	**Fax #** ( )
Name or Contract No.	Reason for Termination:			

REQUIRED FORMS - EXHIBIT 5

CERTIFICATION OF NO CONFLICT OF INTEREST

The Los Angeles County Code, Section 2.180.010, provides as follows:

CONTRACTS PROHIBITED

Notwithstanding any other section of this Code, the County shall not contract with, and shall reject any proposals submitted by, the persons or entities specified below, unless the Board of Supervisors finds that special circumstances exist which justify the approval of such contract:

1. Employees of the County or of public agencies for which the Board of Supervisors is the governing body;

2. Profit-making firms or businesses in which employees described in number 1 serve as officers, principals, partners, or major shareholders;

3. Persons who, within the immediately preceding 12 months, came within the provisions of number 1, and who:

    a. Were employed in positions of substantial responsibility in the area of service to be performed by the contract; or

    b. Participated in any way in developing the contract or its service specifications; and

4. Profit-making firms or businesses in which the former employees, described in number 3, serve as officers, principals, partners, or major shareholders.

Contracts submitted to the Board of Supervisors for approval or ratification shall be accompanied by an assurance by the submitting department, district or agency that the provisions of this section have not been violated.

_____

Proposer Name

_____

Proposer Official Title

_____

Official's Signature

REQUIRED FORMS - EXHIBIT 6

FAMILIARITY WITH THE COUNTY LOBBYIST ORDINANCE CERTIFICATION

The Proposer certifies that:

1) it is familiar with the terms of the County of Los Angeles Lobbyist Ordinance, Los Angeles Code Chapter 2.160;

2) that all persons acting on behalf of the Proposer organization have and will comply with it during the proposal process; and

3) it is not on the County's Executive Office's List of Terminated Registered Lobbyists.

Signature:_____ Date:_____

CALIFORNIA WORK OPPORTUNITY AND RESPONSIBILITY TO KIDS (CalWORKs) RFP

INTENTIONALLY OMITTED

REQUIRED FORMS - EXHIBIT 8

PROPOSER'S EEO CERTIFICATION

_____

Company Name

_____

Address

_____

Internal Revenue Service Employer Identification Number

GENERAL

In accordance with provisions of the County Code of the County of Los Angeles, the Proposer certifies and agrees that all persons employed by such firm, its affiliates, subsidiaries, or holding companies are and will be treated equally by the firm without regard to or because of race, religion, ancestry, national origin, or sex and in compliance with all anti-discrimination laws of the United States of America and the State of California.

CERTIFICATION	YES	NO
1. Proposer has written policy statement prohibiting discrimination in all phases of employment.	( )	( )
2. Proposer periodically conducts a self-analysis or utilization analysis of its work force.	( )	( )
3. Proposer has a system for determining if its employment practices are discriminatory against protected groups.	( )	( )
4. When problem areas are identified in employment practices, Proposer has a system for taking reasonable corrective action to include establishment of goal and/or timetables.	( )	( )

_____ _____

Signature Date

_____

Name and Title of Signer (please print)

REQUIRED FORMS - EXHIBIT 9

ATTESTATION OF WILLINGNESS TO CONSIDER GAIN/GROW PARTICIPANTS

As a threshold requirement for consideration for contract award, Proposer shall demonstrate a proven record for hiring GAIN/GROW participants or shall attest to a willingness to consider GAIN/GROW participants for any future employment opening if they meet the minimum qualifications for that opening. Additionally, Proposer shall attest to a willingness to provide employed GAIN/GROW participants access to the Proposer's employee mentoring program, if available, to assist these individuals in obtaining permanent employment and/or promotional opportunities.

To report all job openings with job requirements to obtain qualified GAIN/GROW participants as potential employment candidates, Contractor shall email: GAINGROW@dpss.lacounty.gov.

Proposers unable to meet this requirement shall not be considered for contract award.

Proposer shall complete all of the following information, sign where indicated below, and return this form with their proposal.

A. Proposer has a proven record of hiring GAIN/GROW participants.

_____ YES (subject to verification by County) _____ NO

B. Proposer is willing to provide DPSS with all job openings and job requirements to consider GAIN/GROW participants for any future employment openings if the GAIN/GROW participant meets the minimum qualifications for the opening. "Consider" means that Proposer is willing to interview qualified GAIN/GROW participants.

_____ YES _____ NO

C. Proposer is willing to provide employed GAIN/GROW participants access to its employee-mentoring program, if available.

_____ YES _____ NO _____ N/A (Program not available)

Proposer's Organization: _____

Signature: _____

Print Name: _____

Title: _____ Date: _____

Telephone No: _____ Fax No: _____

REQUIRED FORMS - EXHIBIT 10

COUNTY OF LOS ANGELES CONTRACTOR EMPLOYEE JURY SERVICE PROGRAM CERTIFICATION FORM AND APPLICATION FOR EXCEPTION

The County's solicitation for this Request for Proposals is subject to the County of Los Angeles Contractor Employee Jury Service Program (Program), Los Angeles County Code, Chapter 2.203. All proposers, whether a contractor or subcontractor, must complete this form to either certify compliance or request an exception from the Program requirements. Upon review of the submitted form, the County department will determine, in its sole discretion, whether the proposer is excepted from the Program.

Company Name:		
Company Address:		
City:	State:	Zip Code:
Telephone Number:		
Solicitation For _____ Services:		

If you believe the Jury Service Program does not apply to your business, check the appropriate box in Part I (attach documentation to support your claim); or, complete Part II to certify compliance with the Program. Whether you complete Part I or Part II, please sign and date this form below.

Part I: Jury Service Program is Not Applicable to My Business

- ☐ My business does not meet the definition of "contractor," as defined in the Program, as it has not received an aggregate sum of $50,000 or more in any 12-month period under one or more County contracts or subcontracts (this exception is not available if the contract itself will exceed $50,000). I understand that the exception will be lost and I must comply with the Program if my revenues from the County exceed an aggregate sum of $50,000 in any 12-month period.

- ☐ My business is a small business as defined in the Program. It 1) has ten or fewer employees; and, 2) has annual gross revenues in the preceding twelve months which, if added to the annual amount of this contract, are $500,000 or less; and, 3) is not an affiliate or subsidiary of a business dominant in its field of operation, as defined below. I understand that the exception will be lost and I must comply with the Program if the number of employees in my business and my gross annual revenues exceed the above limits.

  "Dominant in its field of operation" means having more than ten employees and annual gross revenues in the preceding twelve months, which, if added to the annual amount of the contract awarded, exceed $500,000.

  "Affiliate or subsidiary of a business dominant in its field of operation" means a business which is at least 20 percent owned by a business dominant in its field of operation, or by partners, officers, directors, majority stockholders, or their equivalent, of a business dominant in that field of operation.

- ☐ My business is subject to a Collective Bargaining Agreement (attach agreement) that expressly provides that it supersedes all provisions of the Program.

OR

Part II: Certification of Compliance

- ☐ My business has and adheres to a written policy that provides, on an annual basis, no less than five days of regular pay for actual jury service for full-time employees of the business who are also California residents, **or** my company will have and adhere to such a policy prior to award of the contract.

I declare under penalty of perjury under the laws of the State of California that the information stated above is true and correct.

Print Name:	Title:
Signature:	Date:

REQUIRED FORMS - EXHIBIT 11

CHARITABLE CONTRIBUTIONS CERTIFICATION

_____

Company Name

_____

Address

_____

Internal Revenue Service Employer Identification Number

_____

California Registry of Charitable Trusts "CT" number (if applicable)

The Nonprofit Integrity Act (SB 1262, Chapter 919) added requirements to California's Supervision of Trustees and Fundraisers for Charitable Purposes Act which regulates those receiving and raising charitable contributions.

Check the Certification below that is applicable to your company.

☐ Proposer or Contractor has examined its activities and determined that it does not now receive or raise charitable contributions regulated under California's Supervision of Trustees and Fundraisers for Charitable Purposes Act. If Proposer engages in activities subjecting it to those laws during the term of a County contract, it will timely comply with them and provide County a copy of its initial registration with the California State Attorney General's Registry of Charitable Trusts when filed.

OR

☐ Proposer or Contractor is registered with the California Registry of Charitable Trusts under the CT number listed above and is in compliance with its registration and reporting requirements under California law. Attached is a copy of its most recent filing with the Registry of Charitable Trusts as required by Title 11 California Code of Regulations, sections 300-301 and Government Code sections 12585-12586.

_____ _____

Signature Date

_____

Name and Title of Signer (please print)

REQUIRED FORMS - EXHIBIT 12

CERTIFICATION OF COMPLIANCE WITH THE COUNTY'S DEFAULTED PROPERTY TAX REDUCTION PROGRAM

Company Name:		
Company Address:		
City:	State:	Zip Code:
Telephone Number:	Email address:	
Solicitation/Contract For _____ Services:		

The Proposer/Bidder/Contractor certifies that:

☐ It is familiar with the terms of the County of Los Angeles Defaulted Property Tax Reduction Program, Los Angeles County Code Chapter 2.206; **AND**

To the best of its knowledge, after a reasonable inquiry, the Proposer/Bidder/Contractor is not in default, as that term is defined in Los Angeles County Code Section 2.206.020.E, on any Los Angeles County property tax obligation; **AND**

The Proposer/Bidder/Contractor agrees to comply with the County's Defaulted Property Tax Reduction Program during the term of any awarded contract.

- OR -

☐ I am exempt from the County of Los Angeles Defaulted Property Tax Reduction Program, pursuant to Los Angeles County Code Section 2.206.060, for the following reason:

_____

_____

I declare under penalty of perjury under the laws of the State of California that the information stated above is true and correct.

Print Name:	Title:
Signature:	Date:

Date: _____

REQUIRED FORMS – EXHIBIT 13

CALIFORNIA WORK OPPORTUNITY AND RESPONSIBILITY TO KIDS (CalWORKs) RFP

FINANCIAL CAPABILITY

(Refer to RFP Paragraph 7.8.12.1)

REQUIRED FORMS –EXHIBIT 14
CalWORKs Mental Health Supportive Services

BUDGET INSTRUCTIONS

BUDGET NARRATIVE AND JUSTIFICATION

Provider/Proposer must provide a narrative explaining its proposed budget costs and a justification for the costs.

GENERAL INFORMATION

The budget must clearly indicate that a viable program will be operating within the timeframe allotted for the program. **The budget should be based on the Service Area Allocation per Award.** The Budget Narrative, an attachment to the Budget Form, must provide the formulas (calculations) showing how each dollar amount that appears on the Budget Form was calculated. All amounts are to be rounded off to the nearest dollar.

Please Note:
Following are explanations of the allowable line item categories and examples of how line item amounts are calculated. The examples show how formulas on the required Budget Narrative and Justification should look.

A. PERSONNEL SALARIES (Require 70% Minimum)

1. **Program Staff (Items a-d)**
   - Indicate the staff position and salary for each staff person proposed for program.
   - Indicate the percentage of Employee/Fringe Benefits for each staff classification. This includes FICA, unemployment insurance, workers' compensation, and health insurance. List total Employee/Fringe Benefit Package costs for each staff position.
   - Add the benefit dollar amount to the salary dollar amount to arrive at the combined salary/benefit for each classification.

     EXAMPLE:

     Salary: Project Coordinator @ 4000 mo. X 12 mos. = $48,000

     Employment Benefits: 26% X $48,000 = $12,480

     Total Project Coordinator salary and benefits: $48,000 + $12,480 = $60,480

2. **Consultants (Professional Services)**
   - List the names (if known) and type of consultants to be hired, the annual number of consultations, and the consultation rate. For example:

     EXAMPLE:

     Curriculum Consultant: 50 hours at $200/hour = $10,000

REQUIRED FORMS –EXHIBIT 14
CalWORKs Mental Health Supportive Services

BUDGET INSTRUCTIONS

3. **Administration/Support**
   - Indicate the staff position and salary for each staff person proposed for the program.
   - Indicate the percentage of Employee/Fringe Benefits for each staff classification. This includes FICA, unemployment insurance, workers' compensation, and health insurance. List total Employee/Fringe Benefit Package costs for each staff position.
   - Add the benefit dollar amount to the salary dollar amount to arrive at the combined salary/benefit for each classification.

     EXAMPLE:

     Salary: Project Coordinator @ $2500 mo. X 12 mos. = $30,000

     Employment Benefits: 26% X $30,000 = $7800

     $30,000 + $7800 = Total Project Coordinator salary and benefits)

B. SERVICES AND SUPPLIES COSTS (S&S)

Costs for production/re-production of teaching materials, mailing, office supplies, mileage related to the program may be included if they are not included in the overall administrative costs of the program and can be identified as such for invoicing purposes.

1. **Office Supplies**
   - Specify the costs per month for the duration of the program.

   EXAMPLE:

   Training and Presentation Supplies @100 month X 12 months = $1200

2. **Mileage**
   - Specify the total annual proposed cost for each staff person requiring travel mileage and the basis for computation. Mileage must be computed in accordance with the County's prevailing Rate Schedule.

     EXAMPLE:

     Rate ($0.525) x Number of Miles = Total Mileage Cost

3. **Other (i.e.) Production /re-production of teaching materials**
   - Specify the cost per month for the duration of the program.

C. EQUIPMENT

REQUIRED FORMS –EXHIBIT 14
CalWORKs Mental Health Supportive Services

BUDGET INSTRUCTIONS

"Equipment" means non-expendable personal property, each item of which has (a) a useful life in excess of three years, and (b) a value in excess of Three Thousand Dollars ($3,000). Except as provided for in Section 551, Title 9, equipment expenditures for existing services during any fiscal year shall not exceed one percent (1%) of the net budget of such service, and ten percent (10%) of the net budget for those new services which commence subsequent to the beginning of the fiscal year.

- Purchases: Identify equipment to be purchased, a justification statement for the purchase, and the cost of each equipment. Equipment purchase requests must be submitted to Department of Mental Health and may be reportable to the State Department of Mental Health as necessary.

- Equipment Leases – Identify equipment to be leased, a justification statement for all leased equipment, and the cost of each lease.

D. FACILITY COSTS

Facility Rent/Lease

- Specify the gross square footage, monthly and yearly gross cost, monthly and yearly cost per square foot.
- If facility is currently being rented, attach a copy of the current lease or rental agreement. Rents and purchase costs applied to the contract will be compared to the guidelines issued by the County of Los Angeles - Internal Services Department for evaluating rent costs in the current budget.

E. INDIRECT COSTS

Administrative support and other indirect costs are those incurred for the common benefit of the organization's total contracted program and are not directly or readily attributable to a previously specified direct cost. Allowable administrative costs include accounting, budgeting, financial screening, general administrative personnel, information system, office services, and other such similar services. These costs must be reasonable, be equitably allocated and compliant with federal cost allocation principles. Consult with your accountant. Administrative costs are allowable to the extent they are: 1) reasonable and 2) related to the services provided by the providers.

- **ADMINISTRATIVE COSTS**

  Administrative costs are the indirect costs related to the implementation and operation of the program. Such costs must be reasonable and include a formula on how the cost was calculated.

REQUIRED FORMS - EXHIBIT 14

CalWORKs Mental Health Supportive Services

CalWORKs PROGRAM BUDGET FORM

SAMPLE

PROVIDER/PROPOSER NAME _____

Service Area _____

		PROVIDER SITE STAFFING	FTEs	AMOUNT	% of Total Amount Requested
A. PERSONNEL SALARIES (Require 70% Minimum)					
	1	**PROGRAM STAFF**			
	a	Psychologist/MSW/LCSW/MFT (Lic./Reg./Waiv'd.) MH Clinical Nurse Specialist (CSN)	3.51	$ 209,118	31.1%
	b	RN, LVN, Psych. Tech.	0.07	7,388	1.1%
	c	MH Rehabilitation Specialist	0.21	11,526	1.7%
	d	Mental Health Related B.A. or 2 yrs. MH Experience - not licensed	0.87	39,742	5.9%
	2	**CONSULTANT STAFF *(Professional Services)***	0.25	52,412	8.6%
	3	**ADMINISTRATION/SUPPORT**	2.79	130,980	19.4%
		Total Salaries and Wages (lines 1a-d, 2 and 3)		$ 451,166	67.8%
		Employee Benefits		$ 91,713	13.6%
		TOTAL PERSONNEL SALARIES & EMPLOYEE BENEFITS/FTEs	7.70	$ 542,879	81.4%
B. SERVICES AND SUPPLIES (S&S)					
	1	Office Supplies		$ 41,437	6.2%
	2	Mileage		-	0.0%
	3	Other (Specify)		-	0.0%
		TOTAL SERVICES AND SUPPLIES (lines 1-3)		$ 41,437	6.2%
C. EQUIPMENT *(Purchased with a Unit Value $3,000 or more)*				$ 2,897	0.4%
D. FACILITY COSTS				$ 22,250	3.3%
		SUBTOTAL PERSONNEL/S&S/EQUIPMENT/FACILITY COSTS		$ 609,463	91.3%
E. INDIRECT ADMINISTRATIVE OVERHEAD				$ 64,008	9.5%
		SERVICE AREA ALLOCATION PER /AWARD AMOUNT	**7.70**	**$ 673,471**	**100.8%**

CalWORKs Mental Health Supportive Services

PROGRAM DESCRIPTION

GENERAL INSTRUCTIONS

Please check (√) selection type.

☐ **RENEWALS**

☐ **SUPERSESSION**

☐ **MID-YEAR CHANGES**

☐ **SOLICITATION**

The application must include a Program Description Exhibit for each program that is proposed to be funded through the County of Los Angeles Department of Mental Health's (LACDMH) Maximum Contract amount (MCA) allocation(s). The template for the Program Description Exhibit is included on Page 2.

For CalWORKs existing providers, a Program Description is required on an annual basis when submitting the Negotiation Package. The annual Negotiation Package submission meets the Memorandum of Understanding guidelines developed by the Department of Public Social Services for the CalWORKs Program.

HEADING INSTRUCTIONS: (Enter the Service Area)

1. Enter the Program Name.
2. Enter the Fiscal Year(s).
3. Enter the Legal Entity Name.
4. Enter the State/County assigned Legal entity Number. New service providers are to enter "TBD" (To Be Determined).
5. Enter the Supervisorial District(s) to be served.

COMPLETE THE FOLLOWING QUESTIONS ON PAGES 2 – 5.
IF NOT APPLICABLE ENTER N/A.

CalWORKs Mental Health Supportive Services

PROGRAM DESCRIPTION

SERVICE AREA

1. CalWORKs PROGRAM NAME:

Authorized Program(s) can be identified by the Los Angeles County Department of Mental Health's allocation worksheet for existing contractors and in the Solicitation document for prospective contractors and/or new programs.

2. FISCAL YEAR (S):

3. LEGAL ENTITY NAME:

4. LEGAL ENTITY NUMBER:

Enter the State/County assigned Legal Entity Number. New service providers are to enter "TBD" (To Be Determined).

5. SUPERVISORIAL DISTRICT(S) TO BE SERVED:

6. Number of Unique (Unduplicated Count) Clients to be Served:

7. Estimated Average Cost per Unique (Unduplicated Count) Client to be Served:

8. Number of dedicated client slots for fiscal year.

9. List procedures in the event the program reaches its capacity at any point during the proposed contract term.

10. What is the procedure for managing wait lists, referrals and Continuity of Care?

CalWORKs Mental Health Supportive Services

PROGRAM DESCRIPTION

11. Special Characteristics of Population to be Served:

a. Percentage of monolingual non-English speaking clients to be served under this proposed program?

b. Other (developmentally disabled, substance use disorder, domestic violence, etc.):

12. Public Transportation Access. List each facility site and for each facility site describe the public access to the site. Be specific as to the distance of the closest bus, light rail, subway or other public transportation stop.

13. Staff Training and Supervision. Describe the nature, frequency and method of supervision for all staff including master's-level student interns and volunteers. How are new staff oriented and trained to provide CalWORKs mental health services? Are there in-service trainings to increase staff awareness of and sensitivity to ethnic and cultural issues? Is there training in specific topics such as CalWORKs GAIN documentation or non-violent crisis intervention that is required for staff to attend?

14. Program Description: Provide a program description including but not limited to the following topics:

a. Program's purpose

b. For newly funded CalWORKs programs, describe the implementation plan and timeline, including the respective effective dates for the beginning of start-up work and the availability of service delivery.

c. Identify the demographics of the geographic area to be served.

d. Explain the appropriateness of the staffing profile that is required to meet the needs of the target population to be served.

CalWORKs Mental Health Supportive Services

PROGRAM DESCRIPTION

e. Goals of the Program

f. Describe services to be provided to include the following:

i. Describe the program's outreach, referral, admission and engagement processes:

How are the organizations' services publicized to the public/target population (e.g. Directory listings, mailings, advertisements, community memberships, coalitions, neighborhood councils, faith-based organizations, etc.)?

ii. Intake Procedure: Describe the intake procedure for CalWORKs participants. How does GAIN Services Workers (GSW) contact the centralized appointment desk to obtain an assessment appointment? How is facsimile contact from GSWs handled? Explain intake procedure and scheduling of assessment appointments within the DPSS priority levels. Are there specific hours to accept new intakes?

iii. Describe the training provided to CalWORKs staff on the GAIN program and GAIN documentation. Describe ongoing coordination of services with GSW.

iv. Which evidence-based practices (EBP) are utilized specifically for the CalWORKs population? How is staff trained on the EBPs? What outcomes are collected to ensure efficacy of the identified EBPs?

v. What is the process for access to psychiatric evaluation and medication support services?

vi. Are clients routinely referred for general physicals? Are general medical services available on site?

CalWORKs Mental Health Supportive Services

PROGRAM DESCRIPTION

vii. Do agency physicians consult with the consumer's primary care physician to promote the overall health of the consumer?

viii. Describe how case management, linkages, peer support, and other support services are provided?

ix. Describe how crisis intervention services (telephone 24/7 or face-to-face) will be provided.

x. Describe dis-enrollment procedures including minimum of three contact attempts prior to disenrollment (i.e., telephone call, letter, home visit), referrals for continuity of care, and communication with GAIN.

xi. Describe the role and functions of any program partners.

xii. Describe how Supported Employment Individual Placement and Support Services will be provided to CalWORKs participants. Include the referral and eligibility process, the role of supported employment staff, and employment-related community partners.

xiii. Provide any additional details that you believe are pertinent about the program.

REQUIRED FORMS – EXHIBIT 15

COUNTY OF LOS ANGELES- DEPARTMENT OF MENTAL HEALTH
CONTRACTS DEVELOPMENT AND ADMINISTRATION DIVISION

LEGAL ENTITY (LE) AGREEMENT NEGOTIATION PACKAGE EFFECTIVE JULY 1, 2014

FOR

□ RENEWALS, □ SUPERSESSION, □ MID-YEAR CHANGES and □ SOLICITATIONS

(Please check (√) selection type)

REQUIRED FORMS – EXHIBIT 15
TABLE OF CONTENTS

REQUIRED FORMS – EXHIBIT 15

INTRODUCTION TO THE NEGOTIATION PACKAGE

1. Purpose of the DMH Negotiation Package:
   a. **CalWORKs Provider** program information submitted in the Negotiation Package by each Legal Entity will be used for DMH's evaluation of the agency's compatibility with the County's service delivery system, integration with the DMH's claims processing information and claims reimbursement systems, contract monitoring, and contract auditing.

   b. In the event a contract is awarded, the Negotiation Package is by reference an extension of the Legal Entity Contract and will be used for monitoring but not reimbursement purposes.

   c. *Any requests for changes to the Legal Entity Agreement requires an updated Negotiation Package which must be approved by the* lead *DMH District Chief and Deputy Director as provided by DMH Notice, Negotiation Package Submission Procedure.*

2. The Negotiation Package Submission Process:
   a. *Effective July 1, 2014,* the Negotiation Package was designed to capture the total program funding information by ***Provider Site location*** (irrespective of individual programs operating within specific facility sites, i.e., CalWORKs, PEI, FSP, EPSDT, etc.). In order to appropriately evaluate and monitor CalWORKs program activities operating at the provider site location, a separate Negotiation Package (Schedules 1-9) is required for the CalWORKs program. Please note that a separate Negotiation Package is also required when submitting for contract renewals, supersession, mid-year changes and solicitation purposes.

   b. After completing the appropriate negotiation package schedules, submit an **original and 1 copy (or more if required by Contract Administrator or Solicitation requirements)** on or before the specified submission date for the period.

   c. **Completed negotiation packages should be submitted to:**

      County of Los Angeles-Department of Mental Health
      Contracts Development and Administration Division
      550 South Vermont Avenue, 5th Floor
      Los Angeles, CA 90020

      Solicitation: Negotiation Packages submitted through this process must be included in the Required Forms – Exhibit 14A (Budget Forms section) as stated in solicitation requirements.

   d. The original Negotiation Package and each copy are to be typewritten and bound separately prior to submission.

REQUIRED FORMS – EXHIBIT 15

INTRODUCTION TO THE NEGOTIATION PACKAGE

e. Failure to complete: An incomplete Negotiation Package will be returned to sender/contractor. The contractor may experience a significant delay in the execution of their related contract action/approval due to failure to complete their negotiation package.

Solicitation: An incomplete Negotiation Package submitted through this process may impact overall score earned in the Budget Forms Section.

3. **DMH personnel may request at any time additional information to support a submitted Negotiation Package prior to approving the document.**

Solicitation: A Negotiation Package submitted through the solicitation process may not be revised or corrected once proposal has been officially received by the Contracts Development and Administration Division.

4. Public Record. At such time as the DMH Director recommends a contract to the Board of Supervisors, and such recommendation appears on the Board agenda, all Negotiation Package material submitted shall become a matter of public record, with the exception of those elements in each Negotiation Package that are defined by the contractor as business or trade secrets and plainly marked as "Trade Secret", "Confidential", or "Proprietary". The County shall not in any way be liable or responsible for the disclosure of any such records or any part thereof if disclosure is required or permitted under the California Pubic Records Act or otherwise by law.

5. No funds can be disbursed by DMH until the Board of Supervisors has approved the contract. Funds can only be disbursed in accordance to the Terms and Conditions of the contract and in no case can disbursements exceed the contract's Maximum Contract Amount (MCA) and/or the total for each respective **Funded Program** identified in the Legal Entity Agreement's **Financial Summary**.

6. Standardized Templates:
The Negotiation Package Schedules in this package must be used for "Contract Renewal", Supersession, "Solicitation" and/or "Mid-Year Change" purposes.

   a. The Negotiation Package schedules are created in Microsoft EXCEL.

   b. Based on the contract period, the appropriate schedules must be submitted in order for the Negotiation Package to be considered complete.

   c. Negotiation Package Schedules are identified in sequential number order and include Schedules 1-9. (See Section 9, Pages I-3 to I-4)

REQUIRED FORMS – EXHIBIT 15

INTRODUCTION TO THE NEGOTIATION PACKAGE

d. Each Negotiation Package Schedule is **password protected**. The protection password is in small case: *dmh*.

e. If applicable, it is the responsibility of the preparer to make and/or validate any link(s) between Negotiation Package schedules.

f. It is the preparer's responsibility to mark any requirements in any of the schedules that do not apply to their agency/programs as N/A.

7. The Proposed DMH Funds to be reported in Schedules 6-9 of the Negotiation Package should be taken from the following:
   a. Existing contractors will need to have received from the DMH a planning notification of the initial and/or revised funded program allocations in order to adequately prepare this Negotiation Package budget. They may also receive a worksheet reflecting their utilization and historical mental health services data from the prior fiscal year.

   b. Prospective contractors will need to have received a solicitation notice from DMH providing the necessary information for preparation of a proposed budget in response to the solicitation.

8. Mid-Year Contract Changes:
   a. A Mid-Year Change Negotiation Package is mandatory whenever, during a fiscal year, a modification to the terms and conditions of an existing Board of Supervisor's approved contract is proposed. A Mid-Year Change Negotiation Package is required for all contract changes regardless if the change(s) resulted in a formal contract amendment. These changes include, but are not limited to:

      i) An increase or decrease in the Funded Program Amount and/or MCA;

      ii) A modification in the previously approved Subprogram(s) amounts or service levels that reflects:
         - A 15% variance across the Legal Entity (i.e. Schedules 7, 8 and 9) or
         - A 25% variance at the Provider Site/Provider Number (Schedules 6 and 8);

      iii) Significant changes in the target population; and/or

      iv) Impact to the quantity or quality of client care; and/or

      v) Change in service location and/or hours of operation.

REQUIRED FORMS – EXHIBIT 15

INTRODUCTION TO THE NEGOTIATION PACKAGE

b. When requesting a Mid-Year Change to a Board of Supervisors approved contract, Contractors are required to submit all relevant Negotiation Package Schedules reflecting the requested change.

9. Negotiation Package Submission Documents and Sequence Order:

   a. Schedule 1: **Transmittal Letter**
   b. Schedule 2: **Legal Entity Contract Information Sheet**
   c. Schedule 3: **Legal Entity - CalWORKs Provider Operating Days and Hours**
   d. Schedule 4: **Legal Entity - CalWORKs Provider Service Capacity**
   e. Schedule 5: **Legal Entity - Covered Services by CalWORKs Provider**
   f. Schedule 6: **CalWORKs Provider Budget by Service Area**
   g. Schedule 7: **Legal Entity - CalWORKs Provider Budget Summary**
   h. Schedule 8: **Legal Entity – CalWORKs Provider Mental Health Services Plan**
   i. Schedule 9: **CalWORKs - Subprogram Schedule**

Next Steps:

a. Read the Instructions.

   Important note: For the purposes of Negotiation Packages submitted according to instructions for Renewals, Supersession, Mid-Year Changes and Solicitations.

b. Based on the contract period, complete the appropriate Negotiation Package schedules.

c. Submit completed Negotiation Package according to the "Negotiation Package Submission Instructions" by the submission due date for the contract period.

REQUIRED FORMS– EXHIBIT 15

INSTRUCTIONS FOR COMPLETING THE NEGOTIATION PACKAGE

Schedules 1-9 of the Negotiation Package are all included in one Excel Worksheet File saved on the LAC-CDAD Negotiation Package CD. Upon inserting the CD into your computer CD drive, click on the file labeled "Negotiation Package". You will find 9 tabs for each schedule. Please complete Schedules 1-9 as follows:

1. **Schedule 1 Transmittal Letter**
   a. Click on Tab 1: "Schedule 1 – Transmittal Letter"

   b. Select from the dropdown menu, the appropriate Negotiation Package Submission Term in the "NP Submission Term" section

   c. Enter the "Submission Date" and "Legal Entity Name" in the respective highlighted cells. These cells are linked to Schedule 2 Legal Entity Contract Information Sheet entries for "Submission Date" and Legal Entity Name".

   d. Enter a brief description of each contract change that occurred during the period in the "Summary of Changes". All changes should be cumulatively reflected in the Negotiation Package for the period.

   e. Enter the following in the "Contractor Certification" section:
      - Date

      - Typed/printed name of the individual in your agency that is authorized to sign contracts on behalf of the Legal Entity that will sign the Transmittal Letter upon completion of the Negotiation Package.

   f. Signer is to sign in the indicated "Signed" space. The authorized signer should not sign this form until the completed Negotiation Package is ready to be submitted to DMH.

   g. Agency should leave all other sections blank.
      - Do not complete any of the information under the "Department of Mental Health Program Certification" section.

      - Do not complete any of the information under the "Department of Mental Health Contracts Development and Administration Certification" section.

2. **Schedule 2 Legal Entity Contract Information Sheet**
   a. Click on Tab 2: "Schedule 2 – Legal Entity Contract Information Sheet"

   b. Line 1: The "Submission Date" cell will already be populated with the information keyed in this section in Schedule 1 Transmittal Letter.

REQUIRED FORMS– EXHIBIT 15

INSTRUCTIONS FOR COMPLETING THE NEGOTIATION PACKAGE

c. Line 2: Enter the fiscal year(s) for which the Negotiation Package proposal is applicable.

d. Line 3-4: Enter the "Reason for the NP Proposal": Renewal, Supersession, Amendment, Solicitation, or Contract Modification not requiring an Amendment.

e. Line 5-7: If the proposal is for a full fiscal year enter a check in the line 6 cell. If the proposal is for a Mid-Year change enter into line 7 the period to be covered.

f. Line 8: The "Legal Entity Name" cell will already be populated with the information keyed in this section in Schedule 1 Transmittal Letter.

g. Line 9: If the organization has a "Doing Business As" (DBA) Name, enter the DBA Name in this section.

h. Line 10: If DMH has assigned a "Legal Entity Number" enter the number. If no number has been assigned enter "TBD" (To be Determined). DMH will assign a "Legal Entity Number" at a later date if a contract/contract amendment is awarded

i. Line 11: Enter the organization's nine digit federal Tax Identification Number.

j. Lines 12-15: Enter the address for the organization's administrative headquarters or main office.

k. Line 16: Check the appropriate organization status, either Not For Profit or For Profit.

l. Line 17: Indicate the correct LAC-Supervisorial District in which the organization's headquarters/central office is located.

m. Lines 18-21: Enter the requested contact information for the person that is designated as the primary lead to communicate with the DMH in regard to Negotiation Package matters.

n. Line 22: Enter the organization's website address.

o. Line 23: Enter current or prior DMH contract number. If the agency does not have a prior/current contract, and has indicated a Legal Entity Number "TBA", then enter N/A on Line 23.

REQUIRED FORMS– EXHIBIT 15

INSTRUCTIONS FOR COMPLETING THE NEGOTIATION PACKAGE

p. Line 24: List all existing contracts the agency has with other Los Angeles County Departments (if additional space is required, attach a separate sheet to the Negotiation Package to complete the agency's list.)

q. Line 25-29: Check all status(es) that apply to the Legal Entity.

3. **Schedule 3: Legal Entity – CalWORKs Provider Operating Days and Hours**
Schedule 3 reports the days and hours all service facility sites under the Provider's Legal Entity Agreement are open (irrespective of individual programs operated within specific facility sites). Enter operating days and hours, provider number and facility name for the CalWORKs Program reported for this provider site location.

Agencies should list all facilities by provider number on Schedule 3. For field based programs, the main site/facility where the program is coordinated and managed should be listed with the appropriate provider number.

a. Click on Tab 3: "Schedule 3 – Legal Entity Provider Sites Operating Days and Hours"

b. Line 1: The "Submission Date" cell will already be populated with the information keyed in this section in Schedule 1 Transmittal Letter.

c. Line 2: The fiscal year(s) for which the Negotiation Package proposal is applicable is already populated from Schedule 2 Legal Entity Contract Information Sheet.

d. Line 3: The "Legal Entity Name" cell will already be populated with the information keyed in this section in Schedule 1 Transmittal Letter.

e. Line 4: The "Legal Entity Number" cell will already be populated with the information keyed in this section in Schedule 2 Legal Entity Contract Information Sheet.

f. Line 5: Review the categories to be entered by column. Column "a" is the Facility Site DMH Provider Number and DMH Provider Site Name (this information should be consistent with Provider's State and DMH file information). Columns "eff" indicate the days of the week and the morning (am) and afternoon/evening (pm) business operations hours for each facility site.

g. Lines/Rows 6-27: Enter the following information.
- In Column "a", enter each Service Facility's DMH provider number and facility name.

REQUIRED FORMS– EXHIBIT 15

INSTRUCTIONS FOR COMPLETING THE NEGOTIATION PACKAGE

- In Column "b": Check if the facility is a satellite Site (a site operating 25 hours or less per week)

- Column "c": Check if the facility is ADA compliant

- Column "d": Check if the facility is open 24 hours, 7 days a week (including holidays)

- Column "e-ff" indicate the actual time (am or pm) the CalWORKs provider site opens and closes Monday through Sunday. Enter the service facility site's open and close time in HH:MM (e.g. 8:15 or 10:30).

  Solicitation: Proposer's service delivery sites shall be open at a minimum from Monday through Friday, from 8:00 A.M. until 5:00 P.M. as stated in the Statement of Work – Section 5.3.

h. Indicate all holidays and other days the agency, or specific CalWORKs provider site, is closed for business.

i. Indicate if agency is closed on a normal business day (i.e. non-holidays) by inserting "c" in the appropriate column/row.

4. **Schedule 4 Legal Entity - CalWORKs Provider Service Capacity**
Schedule 4 reports the service capacity for each facility site under the Provider's Legal Entity Agreement (irrespective of individual programs operated within specific facility sites). The schedule reports provider service capacity as it relates to language capabilities, age groups to be served, specialty populations, and specialty services.
   a. Click on Tab 4: "Schedule 4–Legal Entity Provider Sites Service Capacity"

   b. Line 1: The "Submission Date" cell will already be populated with the information keyed in this section in Schedule 1 Transmittal Letter.

   c. Line 2: The fiscal year(s) for which the Negotiation Package proposal is applicable is already populated from Schedule 2 Legal Entity Contract Information Sheet.

   d. Line 3: The "Legal Entity Name" cell will already be populated with the information keyed in this section in Schedule 1 Transmittal Letter.

   e. Line 4: The "Legal Entity Number" cell will already be populated with the information keyed in this section in Schedule 2 Legal Entity Contract Information Sheet.

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INSTRUCTIONS FOR COMPLETING THE NEGOTIATION PACKAGE

f. Line 5: Review the categories to be entered by column. For columns r-u, aa-jj, kk-tt, and uu-xx indicate the Non-Threshold Languages, Specialty Population, Specialty Services, and Other category respectively for which the provider has capacity.

g. Lines/Rows 6-26: Enter the following information:

- Column "a" is the Facility Site DMH Provider Number and the DMH Provider Site Name (this information should be consistent with the Provider's State and DMH file information).
- Column "b": Indicate the service area in which the site is located.
- Column "c": Indicate the supervisorial district in which the site is located.
- Columns "d-p": Place a check in the appropriate box if the provider site has the capacity to provide services in the indicated Threshold Languages.
- Columns "q-u": Place a check in the appropriate box if the provider site has the capacity to provide services in the indicated Non-Threshold Languages.
- Columns "v-z": Place a check in the appropriate box if the provider site has the capacity to provide services to the indicated age groups
- Columns "aa-jj": Indicate all specialty populations the provider site has the capacity to serve and check the appropriate box. Specialty populations include but are not limited to veterans, HIV/AIDs, Blind, Deaf or Hard of Hearing, LGBTQ2S, and Developmentally Delayed populations.
- Columns "kk-tt": Indicate all specialty services the provider site has the capacity to provide and check the appropriate box. Specialty services include but are not limited long-term and short-term housing, physical health screenings, vocational services and money management services.
- Columns "uu-xx": Indicate any other special capacities the provider site has available and check the appropriate box.

5. **Schedule 5 Legal Entity - Covered Services by CalWORKs Provider**
Schedule 5 identifies the proposed schedule of services/activities by the respective service facility sites at which the organization will make the services/activities available.
   a. Click on Tab 5: "Schedule 5–Legal Entity Covered Services by CalWORKs Provider Site/Number".

REQUIRED FORMS– EXHIBIT 15

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b. Line 1: The "Submission Date" cell will already be populated with the information keyed in this section in Schedule 1 Transmittal Letter.

c. Line 2: The fiscal year(s) for which the Negotiation Package proposal is applicable is already populated from Schedule 2 Legal Entity Contract Information Sheet.

d. Line 3: The "Legal Entity Name" cell will already be populated with the information keyed in this section in Schedule 1 Transmittal Letter.

e. Line 4: The "Legal Entity Number" cell will already be populated with the information keyed in this section in Schedule 2 Legal Entity Contract Information Sheet.

f. Line 5: Review the categories to be entered by column.

g. Lines/Rows 6-25: Enter the following information.

- Column "a" is the Facility Site DMH Provider Number and the DMH Provider Site Name (this information should be consistent with the Provider's State and DMH file information).
- Column "b" indicates the service area in which the site is located.
- Column "c" indicates the Supervisorial District in which the site is located.
- Columns "d-j" place a check in the appropriate box if the provider site has capacity to provide the indicated Outpatient Services (Mode 15) by SFC range.
- Columns "k-l" place a check in the appropriate box if the provider site has capacity to provide the indicated Community Outreach Services (Mode 45) by SFC range.
- Columns "m-p" place a check in the appropriate box if the provider site has capacity to provide the indicated Client Support Services (Mode 60) by SFC range.
- Columns "q-x" place a check in the appropriate box if the provider site has capacity to provide the indicated Day Services (Mode 10) by SFC range.
- Columns "y-rr" place a check in the appropriate box if the provider site has capacity to provide the indicated 24 Hour Services (Mode 5) by SFC range.
- Columns "ss-vv" indicate other covered services the provider site has the capacity to serve and place a check in the appropriate box.

REQUIRED FORMS– EXHIBIT 15

INSTRUCTIONS FOR COMPLETING THE NEGOTIATION PACKAGE

6. **Schedule 6 CalWORKs Program Budget by Service Area**
Schedule 6 (CalWORKs **Provider Budget**) is to be completed for each provider location as identified with a DMH/State assigned Provider Number. Budget and funding for all programs operated within the same Provider Number are to be included in the same Schedule 6. Schedule 6 may be copied for as many Provider Site Budgets as necessary.

Solicitation: For CalWORKs Mental Health Supportive Services, program funding information for Schedule 6 should reflect CalWORKs service activities only.

a. Lines 1, 2, 3a, and 3b. Submission Date, County Fiscal Year, Legal Entity Name, and Legal Entity Number fields are linked to other cells in the worksheet and are protected.

b. Line 4a and 4b. Enter the four-digit Provider Number and service facility site name where CalWORKs service activities are provided.

c. Lines 5a, 5b, 5c, and 5d. Enter the provider site address. Where CalWORKs services are provided.

d. Line 6. Enter the telephone number of the provider site where CalWORKs services are provided.

e. Line 7. Enter the name of the Head of Service or contact person.

f. Line 8. Enter the Service Area for which the Schedule 6 is applicable.

g. Line 9. Enter the County of Los Angeles Supervisor District for which the Schedule 6 is applicable.

h. Line 10. When the Schedule 6 budget expenses and revenues amounts are all entered, there should be no positive or negative numbers appearing in any of the three cells. A number, either positive or negative, in any of the three cells means that the organization's expenses and revenues do not equal each other and the budget has not been correctly prepared.

Provider Staffing for CalWORKs Service activities. – Required 70% minimum for gross CalWORKs Provider Budget and indirect cost for treatment staff for line items 12 thru 19.

i. Lines 12 thru 19, columns b thru e. Enter the FTEs, and Salaries/Wages associated with the personnel identified in lines 12 thru 19, column a.

j. Line 21, columns c and e. Enter the employee benefits associated with the personnel identified on lines 12 thru 19.

REQUIRED FORMS– EXHIBIT 15

INSTRUCTIONS FOR COMPLETING THE NEGOTIATION PACKAGE

k. Lines 24 thru 29, columns c and e. Enter expenses for the respective expense categories listed in column a. (DMH may require Contractor to submit a budget narrative to explain and/or provide detail of certain expenses if deemed necessary.)

Line 28. No entry should be made on this line. Costs for subcontracts will not be allowable for CalWORKs programs.

l. Line 32, columns c and e. Enter the organization's indirect administrative overhead, if any, which is allocated to the provider site for which the Schedule 6 is applicable. Generally accepted cost accounting allocation principles must be used.

m. Lines 35 thru 62, column a. Enter the revenue description that the organization proposes to receive from DMH. The DMH revenue descriptions are provided in the DMH Legal Entity Agreement's Financial Summary and/or solicitation documents released by DMH.

n. Lines 35 thru 62, columns c and e. Enter estimated revenue amounts. All amounts are to be in gross dollar amounts.

o. Lines 65 thru 71, column a. Enter revenue descriptions that the organization expects to receive reimbursement for mental health services from third parties, including reimbursement/revenue from client, insurance, Medicare, and interest associated with funds proposed in lines 35 thru 62.

p. Lines 65 thru 69, columns c and e. Enter the estimated revenue amounts.

7. **Schedule 7 Legal Entity – CalWORKs Provider Budget Summary**
Schedule 7 provides an overview of the *Fund/Revenue Sources* section in Schedule 6 (CalWORKs **Provider Budget**) and Legal Entity level subtotal by Funded Programs.

a. Line 5, columns b thru r (as applicable). Enter Provider Number.

b. Lines 6 thru 33, column a. Select from the dropdown menu, appropriate Fund/Revenue Source(s) (or Funded Program(s)) proposed to fund the provider site(s) associated with the Provider Number(s) entered in columns b thru r. Lines 34 and 35 are blank cells (without dropdown menu) in case a new funding that is not included in the dropdown menu needs to be added.

c. Line 37, column a. Enter Non-County Revenue. This amount should equal Line 72, Total Client, Third Party and Other Revenue, of Schedule 6 (Provider Site Budget) for the same Provider Number.

REQUIRED FORMS– EXHIBIT 15

INSTRUCTIONS FOR COMPLETING THE NEGOTIATION PACKAGE

d. Lines 6 thru 35, column b thru r. Enter the dollar amount for each appropriate Funded Program proposed to fund each provider site entered in columns b thru r. Line 36, Subtotal by Provider Number, should equal Line 63, Total Proposed Maximum Amount, of Schedule 6 (CalWORKs Provider Budget) for the same Provider Number.

e. Line 38, Total by Provider Number should equal Line 73, Total Gross Revenues, of Schedule 6 (CalWORKs Provider Budget) for the same Provider Number.

8. **Schedule 8 Legal Entity - CalWORKs Mental Health Services Plan**
Schedule 8 outlines an agency's plan for providing services for the requested contract period by client beneficiary type. The plan for services will be provided by the agency and organized as follows:

a. At the Legal Entity Level by Mode of Service by Client Beneficiary Type (i.e. Indigent, EPSDT M/C, Non-EPSDT M/C, MCHIP and MCE)

- Lines 6, 9, 12, and 15; Columns d, f, h, j, and l. Indicate the proposed number of unique clients to be served.

- Lines 7, 10, 13, and 16; Columns d, f, h, j, and l. Indicate the proposed total Units of Services to be provided.

- Lines 8, 11, 14, and 17; Columns d, f, h, j, and l. Indicate the proposed total funding amount to be used.

- Lines 6, 9, 12, and 15; Column n. Indicate the proposed total number of unique clients to be served. **NOTE**: Total unique client number in Column n may not equal the client sum of Columns d, f, h, j, and l if identical client is reported in multiple Client Beneficiary Type due to eligibility change during the fiscal year. For this same reason, the Row Percentage in Column o may be equal to or greater than 100 per cent.

b. **At the Provider Site Level**

- Column a. Indicate the Provider number and site name where CalWORKs services are provided.
- Column b. Indicate the Service Area in which the provider site is located.
- Column c. Indicate the Supervisorial District in which the provider site is located.

REQUIRED FORMS– EXHIBIT 15

INSTRUCTIONS FOR COMPLETING THE NEGOTIATION PACKAGE

- By Client Beneficiary Type (i.e. Non-MC/Indigent, EPSDT MC, Non-EPSDT MC, MCHIP and MCE):
  1) Lines 20, 23, 26, 29, 32, 35, and 38; Columns d, f, h, j, and l. Indicate the proposed number of unique clients to be served.
  2) Lines 21, 24, 27, 30, 33, 36, and 39; Columns d, f, h, j, and l. Indicate the proposed total Units of Services to be provided.
  3) Lines 22, 25, 28, 31, 34, 37, and 40; Columns d, f, h, j, and l. Indicate the proposed total funding amount within the provider's contract to be provided.
  4) Lines 20, 23, 26, 29, 32, 35, and 38; Column n. Indicate the proposed total number of unique clients to be served. **NOTE**: Total unique client number in Column n may not equal the client sum of Columns d, f, h, j, and l if identical client is reported in multiple Client Beneficiary Type due to eligibility change during the fiscal year. For this same reason, the Row Percentage in Column o may be equal to or greater than 100 per cent.

9. **Schedule 9 CalWORKs - Subprogram Schedule**
   a. At the time of the Legal Entity Agreement Renewal/Supersession, DMH will provide Contractor with a completed Schedule 9 (Subprogram Schedule) consistent with the Renewal/Supersession contract amount. Thereafter, when changes are made to the Financial Summary and/or Subprogram Schedule, Contractor is responsible for updating Schedule 9 (Subprogram Schedule) for review and approval of the Lead District Chief.

10. **Historical Mental Health Service Data (to be used as a back up to Schedule 8)**

    DMH will provide each agency with historical data on the services provided by the agency in the previous fiscal year. When completing Schedule 8, providers should consider historical data, funding allocations, existing/anticipated service trends, and the communities/target populations to be served.

    Historical data will be organized as follows:
    a. At the Legal Entity Level by Mode of Service, by Client Beneficiary Type (i.e. Non-MC/Indigent, EPSDT MC, Non-EPSDT MC, MCHIP and MCE). The historical information will include the number of unique clients, the amount of funding used, and the units of service provided.
    b. Historical information will include unique client count, amount of funding utilized, and units of service/days of service used by Service Type, Mode of Service, and Service Function Code Range.

REQUIRED FORMS – EXHIBIT 15

NEGOTIATION PACKAGE SUBMISSION INSTRUCTIONS

Based on paragraph K of the Financial Exhibit A of the Legal Entity Agreement, monitoring of services and claiming for the requested period will be based on the proposed Legal Entity Mental Health Services Plan (Schedule 8) and other information outlined in the provider's financial summary and approved Negotiation Package. Therefore, timely completion, submission and approval of the Negotiation Package are required. To ensure proper submission and approval of the Negotiation Package providers must:

a. Complete the appropriate Negotiation Package schedules as outlined in the "Instructions for Completing the Negotiation Package" by the due date as requested.

b. Submit the appropriate Negotiation Package to DMH Contracts Development and Administration Division.

c. DMH Contracts Development and Administration Division will distribute the Negotiation Package as appropriate for review by DMH units impacted by the provider's proposed service plan.

d. If necessary, the Lead District Chief (or their designee) will follow up with provider's listed point of contact to discuss any needed revisions, concerns or required clarifications.

e. Once all information is approved, the Lead District Chief will sign Schedule 1 Department of Mental Health Program Certification: Signed Program/Bureau District Chief Approval section and forward the document to the appropriate Deputy Director for signature.

f. The Deputy Director will sign Schedule 1 Department of Mental Health Program Certification: Signed Deputy Director Approval section and forward the document to Contracts Development and Administration Division for signature and finalization of the Negotiation Package.

g. The finalized/approved Negotiation Package will be sent to the appropriate contract monitors for ongoing follow up with the provider.

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TERMS, DEFINITIONS, AND ACRONYMS

1. **Beneficiary Types**:

    - Non-Medi-Cal/Indigent: Individuals who are not eligible for Short-Doyle/Medi-Cal, Medi-Cal Expansion, EPSDT or State Children's Health Insurance Program.

    - EPSDT Medi-Cal: beneficiaries eligible for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program.

    - Non-EPSDT Medi-Cal: beneficiaries eligible for Short Doyle/Medi-Cal program for certain individuals with low incomes and resources such as children and families, pregnant women, seniors, and persons with disabilities.

    - MCHIP (includes Healthy Families transition to Medi-Cal Program): Expanded Medicaid Children's Health Insurance Program under Title XXI of the Social Security Act.

    - MCE (Medicaid Expansion): beneficiaries eligible for Medi-Cal coverage expansion under the Affordable Care Act.

2. **Department of Mental Health (DMH)** refers to the County of Los Angeles Department of Mental Health.

3. **Direct Costs** are those that can be identified specifically with a final cost objective (i.e. a particular financial award, project, service, or other direct activity of the organization.

4. **Equipment,** Major means movable personal property of a relatively permanent nature and of significant value meaning $5,000 or more. Allowable to the extent the equipment costs are capitalized and captured through depreciation, unless the County contract specifically approves outright purchase in which case the lower of the contract authorized purchase amount or the equipment actual costs is allowable. No further allowability through depreciation is allowed for lump-sum outright purchases. (Ref. Centers for Medicare and Medicaid Services (CMS), The Provider Reimbursement Manual – Part 1, Chapter 1 Depreciation; County of Los Angeles Fiscal Manual, Chapter 6 Fixed Assets, and California Code of Regulations (CCR) Title 9 Division 1, Section 552 Equipment Expense).

5. **Equipment,** Minor means portable equipment items costing less than $5,000 per unit are allowable expenses under the services and supplies category.

6. **Funded Program** is a set of services paid through a particular funding source for the benefit of a specific beneficiary (e.g., Medi-Cal/Healthy Families or Non-Medi-

REQUIRED FORMS – EXHIBIT 15

TERMS, DEFINITIONS, AND ACRONYMS

Cal/Non-Healthy Families). The Funded Program Amount is the basis for the provisional payment to the Contractor per Paragraph E of the Financial Exhibit A of LAC-DMH LE Agreement. A Funded Program is made up of one or more Subprograms.

7. **Indirect costs** are those that have been incurred for common or joint purposes. These costs benefit more than one cost objective and cannot be readily identified under a particular final cost objective without effort disproportionate to the results received.

8. **Lead District Chief** is the DMH person that is designated to be the primary DMH liaison with the Legal Entity.

9. **Legal Entity (LE)** means a mental health provider whose legal Schedule may be an association, corporation, partnership, sole proprietorship, or other legal Schedule of organization recognized by the State of California. The terms "organization", "agency", "company", and "contractor" may be used interchangeably with "LE".

10. **Licensed clinical/treatment staff.** See the California Code of Regulations, Title 9, Division 1 – Mental Health, Article 8, Professional and Technical Standards, Section 620 – 632 for information regarding the license/degree categories that are used in the program personnel sections of this Negotiation Package.

11. **Maximum Contract Amount (MCA)** is the maximum reimbursement from DMH possible under the Terms and Conditions of a LE Agreement. MCA control applies to the grand total of all programs within the entire LE Agreement and also to the respective "Funded Programs" within the LE Agreement as defined in the LE Agreement's Financial Summary.

12. **Mid-Year/Partial Year Change** is specific portions of the Negotiation Package document that the DMH requires be submitted when amending a LE Agreement during the LE Agreement's Term.

13. **Negotiation Package (NP)** is the document that the DMH requires a service provider to submit when requesting a contract renewal, or a contract award under a solicitation, or a mid-year changes to a current contract.

14. **Provider Number** is a four-character numeric or alpha-numeric code assigned by DMH in collaboration with the State Department of Mental Health. Generally, the provider number is assigned to a specific geographic four-wall facility site; however, in certain circumstances there could be more than one provider number assigned to the same site. In the case of solicitations involving a site for which there is no currently assigned provider number the service provider is to use TBA (to be assigned) followed by a – (dash) 1 (number consecutively) for each proposed new site (i.e. TBA-1, TBA-2, etc.).

REQUIRED FORMS – EXHIBIT 15

TERMS, DEFINITIONS, AND ACRONYMS

15. **Provider Site** is the physical facility at which the services/activities will be rendered and/or coordinated if such services/activities will be rendered in the field.

16. **Service Area (SA)** is a geographically defined area used by DMH to divide the County of Los Angeles into smaller units for the operation of the public mental health system. There are eight (8) SA, which are identified in the DMH's County web page.

17. **Service provider/provider** is a non-government organization (NGO) that proposes to or currently does render mental health services and/or activities.

18. **Solicitation** means a DMH issued Request for Proposal (RFP), Request For Information (RFI), Request for Service (RFS), or Request for Statement of Qualifications (RFSQ).

19. **Subprogram** is a set of services for a specific purpose. The Subprogram Amounts are allocated and/or awarded based on Contractors' areas of expertise and their ability to provide specific services and/or serve specific populations. The Subprogram Amounts will be used to monitor the provision of mental health services within the Funded Program and will not be used at cost settlement.

REQUIRED FORMS - EXHIBIT 15
CalWORKs MH Supportive Services
TRANSMITTAL LETTER
Data entry cells are highlighted

NP Submission Term:

Submission Date:

TO: Department of Mental Health, Contract Development and Administration Division

RE: Legal Entity Name:
(As appears on the organization's Articles of Incorporation)

Summary of Changes: include only changes from the last approved Negotiation Package (if additional space is needed, attach another sheet)

1		8	
2		9	
3		#	
4		#	
5		#	
6		#	
7		#	

Contractor Certification:

Enclosed herewith is the completed Contract Negotiation Package for the organization and fiscal year(s) period(s) shown on Form 2 *Contract Application*. It is correct to the best of my knowledge and represents my organization's proposal for the provision of mental health services/activities for the County.

I certify that services proposed herein meet or exceed the applicable program standards as set forth in the Welfare and Institutions Code and the California Code of Regulations:

Signed (Legal Entity person authorized to sign contracts) — Date

Type/Print Name of Signer

Department of Mental Health Program Certification:

I certify that I have reviewed the content of this Contract Negotiation Package and that it meets DMH standards and policies:

Signed Program/Bureau District Chief Approval — Date

Type/Print Name of Signer

Signed Deputy Director Approval — Date

Type/Print Name of Signer

Department of Mental Health Contracts Development and Administration Certification:

We have reviewed the proposed Maximum Contract Amount and it complies with the Department's proposed allocation for the Contract:

Signed CDAD Contract Administrator (including — Date

Type/Print Name of Signer

Signed Approved by Chief of Contracts for Department of Mental Health — Date

Type/Print Name of Signer

REQUIRED FORMS - EXHIBIT 15

CalWORKs Mental Health Supportive Services

LEGAL ENTITY CONTRACT INFORMATION SHEET

Attach to Form 1

Cell instructions: Data entry cells are highlighted.
(unprotect pass word is dmh in small case)

1 Submission Date: January 0, 1900

2 County Fiscal Year(s): _____ FY(s) applicable for the Neg. Pkg

3 Reason for Proposal (check the following for Contract Renewal, Contract Amendment or Solicitation Proposal:

4 Contract Renewal (√): _____ Contract Amendment (√): _____ Solicitation (√): _____
Contract Supersession (√): _____ Contract Modification without Amendment (√): _____

5 Request Period (check the following for Full Fiscal Year or Mid-Year/Partial Year Change:

6 Full Fiscal Year (✓): _____

7 Mid-Year/Partial Year Change (Enter effective period of change (mm/dd/yy to June 30, yyyy)): _____

8 Legal Entity Name (As appears on the organization's Articles of Incorporation): 0

9 Legal Entity DBA (Doing Business As) name, if applicable: _____

10 Legal Entity Number (if assigned by County, otherwise enter TBD (To be Determined): _____

11 Federal Nine-Digit Tax Identification Number for the organization: _____

12 Address of administrative headquarters or main office (may not be a provider site):

13 a Street Number and Name: _____

14 b Room or Suite Number (if any): _____

15 c City/State/Zip Code: _____

16 Organization status is: Not For Profit (check): _____ For Profit (check): _____

17 Supervisor District in which headquarters is located (1st, 2nd, 3rd, 4th or 5th): _____

18 Contact Person: _____ Responsible to communicate with DMH

19 a Title: _____

20 b Telephone No.: _____ Fax No.: _____

21 c e-mail Address: _____

22 d Website: _____

23 If applicable, current or prior County DMH contract number: _____ which expires/expired on (enter date): _____

24 Please list contracts with other Los Angeles County departments (if applicable):

Department Name:	Contract Term:	Contract Type/Service:

Please check if the Legal Entity is (if applicable):

25 ☐ consumer owned and operated

26 ☐ provider of primary health care

27 ☐ provider of substance abuse services

28 ☐ FQHC

29 ☐ FQHC Look-alike

REQUIRED FORMS - EXHIBIT 15

CalWORKs Mental Health Supportive Services

LEGAL ENTITY - CalWORKs PROVIDER OPERATING DAYS AND HOURS

(unprotect pass word is dmh in small case)
Cell Instructions: Data entry cells are highlighted.

1 Submission Date: January 0, 1900
2 County Fiscal Year(s): 0
3 Legal Entity Name: 0
4 Legal Entity Number: 0

Cell format for columns e through ff is h:mm so enter the hour followed by a colon followed by the minutes (i.e., 8:15); Indicate "c" in columns for day(s) in which the facility is closed

(If the facility is open 24 hours per day and 7 days a week enter a check (√ or x) in column d and do not complete columns e through ff for that facility)

	a	b	c	d	e	f	g	h	i	j	k	l	m	n	o	p	q	r	s	t	u	v	w	x	y	z	aa	bb	cc	dd	ee	ff
	SERVICE FACILITY BY PROVIDER SITE (Report the facility's open hours in columns e - ff. Check column b if the facility is a satellite site. Check column c if the facility is ADA compliant. Check column d if the facility is open 24/7 and do not complete e - ff)	Check if facility is a Satellite Site	Check if facility is ADA compliant	Check if facility is open 24/7	MONDAY				TUESDAY				WEDNESDAY				THURSDAY				FRIDAY				SATURDAY				SUNDAY			
5					OPEN		CLOSE		OPEN		CLOSE		OPEN		CLOSE		OPEN		CLOSE		OPEN		CLOSE		OPEN		CLOSE		OPEN		CLOSE	
	PROV # FACILITY NAME				AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
6																																
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REQUIRED FORMS - EXHIBIT 15

CalWORKs Mental Health Supportive Services

LEGAL ENTITY - CalWORKs PROVIDER SERVICE CAPACITY

(unprotect pass word is dmh in small case)
Cell instructions: Data entry cells are highlighted.

1 Submission Date: 1/0/1900

2 County Fiscal Year: 0

3 Legal Entity Name: 0

4 Legal Entity Number: 0

This Schedule is to report various service site capacities including language, age-group, target population, and other specialty service capabilities by provider number location(s) funded under the County mental health contract.
For each provider site, enter a check (√ or x) under columns d - xx if the site has the capacity to provide said provision/service. Use extra space (e.g., col. s - u) to list additional capacity.

	a		b	c	d	e	f	g	h	i	j	k	l	m	n	o	p	q	r	s	t	u	v	w	x	y	z
					THRESHOLD LANGUAGES													NON-THRESHOLD LANGUAGES					AGE-GROUP				
5	PROV NO.	FACILITY NAME	Service Area	Supervisor Dist	Armenian	Arabic	Cantonese	Other Chinese	Cambodian	English	Farsi	Korean	Mandarin	Russian	Spanish	Tagalog	Vietnamese	American /Other Sign Language					0 - 5	5 - 15	16 - 25	26 - 59	60 +
6																											
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REQUIRED FORMS - EXHIBIT 15

CalWORKs Mental Health Supportive Services

LEGAL ENTITY - CalWORKs PROVIDER SERVICE CAPACITY

(unprotect pass word is dmh In small case)
Cell instructions: Data entry cells are highlighted.

1 Submission Date: 1/0/1900

2 County Fiscal Year: 0

3 Legal Entity Name: 0

4 Legal Entity Number: 0

	a		aa	bb	cc	dd	ee	ff	gg	hh	ii	jj	kk	ll	mm	nn	oo	pp	qq	rr	ss	tt	uu	vv	ww	xx
	[redacted]		SPECIALTY POPULATION										SPECIALTY SERVICES										OTHER			
5	PROV NO.	FACILITY NAME																								
6																										
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REQUIRED FORMS - EXHIBIT 15

CalWORKs Mental Health Supportive Services

LEGAL ENTITY - COVERED SERVICES BY CalWORKs PROVIDER

(unprotect pass word is dmh in small case)
Cell instructions: Data entry cells are highlighted.

1 Submission Date: 1/0/1900
2 County Fiscal Year: 0
3 Legal Entity Name: 0
4 Legal Entity Number: 0

This Schedule is to report services/activities rendered at the provider site (provider number location) funded under the County mental health contract.
For each provider site, enter a check (√ or x) under columns d - rr to indicate the services/activities provided at the site. Use extra space in columns ss - vv to list additional capacity.

	a		b	c	d	e	f	g	h	i	j	k	l	m	n	o	p	q	r	s	t	u	v	w	x
	[redacted]				OUTPATIENT SERVICES							OUTREACH		SUPPORT SVCS				DAY SERVICES							
5	PROV NO.	FACILITY NAME	Service Area	Supervisor District	Targeted Case Management	Collateral	Psychological Testing	Mental Health Services	Therapeutic Behavioral Svc	Medication Support Svc	Crisis Intervention	Mental Health Promotion	Community Client Svc	Public Guardian Investigation	Public Guardian Admin	Life Support	Case Mgmt Support	Crisis Stabilization(ER)	Crisis Stabilization(UC)	Vocational	Socialization Day Svc	Day Treatment Int, Half Day	Day Treatment Int, Full Day	Day Rehab, Half Day	Day Rehab, Full Day
					15/4	15/10	15/34	15/40-59	15/58	15/62	15/77	45/10	45/20	60/20	60/30	60/40	60/60	10/24	10/25	10/31	10/41	10/82	10/85	10/92	10/98
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REQUIRED FORMS - EXHIBIT 15

CalWORKs Mental Health Supportive Services

LEGAL ENTITY - COVERED SERVICES BY CalWORKs PROVIDER

(unprotect pass word is dmh in small case)
Cell instructions: Data entry cells are highlighted

1 Submission Date: 1/0/1900
2 County Fiscal Year: 0
3 Legal Entity Name: 0
4 Legal Entity Number: 0

	a		y	z	aa	bb	cc	dd	ee	ff	gg	hh	ii	jj	kk	ll	mm	nn	oo	pp	qq	rr	ss	tt	uu	vv
	[redacted]		24 HOUR SERVICES																				OTHER			
5	PROV NO.	FACILITY NAME	Acute Gen. Hospital	Psych Hosp Forensic	Psych Hosp 21 or under	Admin Day	Psychiatric Health Facility	SNF Acute Intensive	IMD w/o Patch	IMD w/ Patch	IMD w/ Patch MIO	IMD w/ Patch Indigent MIO	IMD Forensic Ind/Pass Day	Crisis Residential	Forensic Inpatient	Trans Res Non Medi-Cal	Residential Pass Day	Transitional Residential	Trans Res Long Term	Semi-Sup Living	Independent Living	MH Rehab Center				
			5/10-18			5/19	5/20	5/30	5/35	5/36-39				5/43	5/50	5/60	5/62	5/65	5/70	5/80	5/89	5/90				
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REQUIRED FORMS - EXHIBIT 15
CalWORKs Mental Health Supportive Services
CalWORKs PROVIDER BUDGET BY SERVICE AREA

(unprotect pass word is dmh in small case)
Cell instructions: → Data entry cells are highlighted.

1 SUBMISSION DATE: January 0, 1900 2 COUNTY FISCAL YEAR(s): 0

3a LEGAL ENTITY NAME: 0 3b LEGAL ENTITY NUMBER: 0

4a PROVIDER NUMBER: 4b FACILITY NAME:

5a PROVIDER SITE ADDRESS: 5b CITY:

5c STATE: 5d ZIP CODE: 6 TELEPHONE #:

Enter only one Provider Number description into the highlighted cell. Schedule 6 is the budget for the identified Provider Site (Provider Number) including Satellite Site(s), if applicable. Use a separate Schedule 6 for each Provider Site.

7 HEAD OF SERVICE: 8 SERVICE AREA: 10 9 SUPERVISOR DISTRICT: 9

10	AN ERROR HAS OCCURRED IF A NUMBER APPEARS IN ANY OF THE ADJACENT THREE (3) CELLS. THE BUDGET EXPENSES AND REVENUES MUST BE EQUAL FOR A BALANCED BUDGET. IF NOT EQUAL AN AMOUNT OTHER THAN "-" WILL APPEAR.		-		-		-

EXPENSES:

	a	b	c	d	e	f	g	h
11	**PROVIDER SITE STAFFING** (from each respective Provider Number) **(REQUIRED 70% MINIMUM)**	PROPOSED BUDGET OR LAST APPROVED BUDGET		MID/PARTIAL-YEAR CHANGE/SOLICITATION REQUEST - ( ) denotes negative amount		PROPOSED NEW/REVISED BUDGET		Column g cell as a percent of the Total Direct program Budget (col g line cells divided by col g, line 31)
		FTE	AMOUNT	FTE	AMOUNT	FTE (b+d)	AMOUNT (c+e)	
12	Physician (MD)/Psychiatrist/MH Nurse Practitioner (NP)					-	-	-
13	Psychologist/MSW/LCSW/MFT (Lic./Reg./Waiv'd.)/MH Clinical Nurse Specialist (CSN)					-	-	-
14	RN, LVN, Psych. Tech.					-	-	-
15	MH Rehabilitation Specialist					-	-	-
16	Mental Health Related B.A. or 2 yrs. MH Experience - not licensed					-	-	-
17	No B.A. or 2 yrs Exp & Student					-	-	-
18	Other Non-Administrative Program Staff					-	-	-
19	Administrative Support Program Staff (exclude indirect staff)					-	-	-
20	**Total Salaries and Wages** (lines 12:19)		-		-		-	-
21	Employee Benefits						-	-
22	**TOTAL PERSONNEL EXPENSE & FTEs** (lines 20 + 21)	-	-	-	-	-	$ -	-
23	**PROGRAM SERVICES AND SUPPLIES**							
24	Equipment, Purchased with a Unit Value $5,000 or more						-	-
25	Facilities and/or Improvements, Purchased with a Unit Value $5,000 or more						-	-
26	One-Time Expenses						-	-
27	Professional Services - Clinical/Program						-	-
28	Subcontracts (program/clinical personnel) **N/A FOR CalWORKs Programs**						-	-
29	All Other Services and Supplies						-	-
30	**TOTAL SERVICES AND SUPPLIES** (sum lines 24:29)		-		-		$ -	-
31	**TOTAL PERSONNEL & SERVICES/SUPPLIES EXPENSES** (lines 22 + 30)		-		-		$ -	
32	**INDIRECT ADMINISTRATIVE OVERHEAD** (Attributed to the general administration.						$ -	-
33	**TOTAL GROSS PROVIDER BUDGET and INDIRECT EXPENSES** (line 22 for FTE count and lines 31 + 32 for dollar amounts)	-	-	-	-	-	$ -	

REQUIRED FORMS - EXHIBIT 15
CalWORKs Mental Health Supportive Services
CalWORKs PROVIDER BUDGET BY SERVICE AREA

(unprotect pass word is dmh in small case)
Cell instructions: → Data entry cells are highlighted.

1 SUBMISSION DATE: January 0, 1900 2 COUNTY FISCAL YEAR(s): 0

3a LEGAL ENTITY NAME: 0 3b LEGAL ENTITY NUMBER: 0

4a PROVIDER NUMBER: 4b FACILITY NAME:

5a PROVIDER SITE ADDRESS: 5b CITY:

5c STATE: 5d ZIP CODE: 6 TELEPHONE #:

Enter only one Provider Number description into the highlighted cell. Schedule 6 is the budget for the identified Provider Site (Provider Number) including Satellite Site(s), if applicable. Use a separate Schedule 6 for each Provider Site.

7 HEAD OF SERVICE: 8 SERVICE AREA: 10 9 SUPERVISOR DISTRICT: 9

	FUND/REVENUE SOURCES (gross dollar amounts by Funded Programs from LE Agreement Financial Summary):						
	a	b	c	d	e	f	g	h
34	**FUND/REVENUE REIMBURSEMENT SOURCES PROPOSED TO BE CONTRACTED WITH COUNTY (The County's contractual and reimbursement control will be the Maximum Contract Amount (MCA) by Funded Program Allocation):**		LAST APPROVED BUDGET		MID-YEAR, PARTIAL YEAR CHANGE OR SOLICITATION REQUEST		PROPOSED NEW/REVISED BUDGET (c+e)	PERCENT OF TOTAL BUDGET (col g cells ÷ column g, line 33)
35	Enter Funded Program Name/Gross Amount						-	-
36	Enter Funded Program Name/Gross Amount						-	-
37	Enter Funded Program Name/Gross Amount						-	-
38	Enter Funded Program Name/Gross Amount						-	-
39	Enter Funded Program Name/Gross Amount						-	-
40	Enter Funded Program Name/Gross Amount						-	-
41	Enter Funded Program Name/Gross Amount						-	-
42	Enter Funded Program Name/Gross Amount						-	-
43	Enter Funded Program Name/Gross Amount						-	-
44	Enter Funded Program Name/Gross Amount						-	-
45	Enter Funded Program Name/Gross Amount						-	-
46	Enter Funded Program Name/Gross Amount						-	-
47	Enter Funded Program Name/Gross Amount						-	-
48	Enter Funded Program Name/Gross Amount						-	-
49	Enter Funded Program Name/Gross Amount						-	-
50	Enter Funded Program Name/Gross Amount						-	-
51	Enter Funded Program Name/Gross Amount						-	-
52	Enter Funded Program Name/Gross Amount						-	-
53	Enter Funded Program Name/Gross Amount						-	-
54	Enter Funded Program Name/Gross Amount						-	-
55	Enter Funded Program Name/Gross Amount						-	-
56	Enter Funded Program Name/Gross Amount						-	-
57	Enter Funded Program Name/Gross Amount						-	-
58	Enter Funded Program Name/Gross Amount						-	-
59	Enter Funded Program Name/Gross Amount						-	-
60	Enter Funded Program Name/Gross Amount						-	-
61	Enter Funded Program Name/Gross Amount						-	-
62	Enter Funded Program Name/Gross Amount						-	-
63	**Total Proposed Maximum Amount** (sum lines 35:62)		-		-		$ -	-
64	**Client, Third Party and Other Non-County Revenues:**							
65	Client Fees						-	-
66	Insurance						-	-
67	Interest (on any funds associated with any of the funds lines 35:62)						-	-
68	Medicare						-	-
69	Enter Other Revenues						-	-
70	Enter Other Revenues						-	-
71	Enter Other Revenues						-	-
72	**Total Client, Third Party and Other Revenue** (sum lines 65:71)		-		-		$ -	-
73	**TOTAL GROSS REVENUES** (lines 63 + 72)		-		-		$ -	-

REQUIRED FORMS - EXHIBIT 15
CalWORKs Mental Health Supportive Services
LEGAL ENTITY - CalWORKs PROVIDER BUDGET SUMMARY

1 Submission Date: 1/0/1900
2 County Fiscal Year: 0
3 Legal Entity Name: 0
4 Legal Entity Number: 0

This schedule is to report funded programs and amounts by provider site (provider number location) funded under the County mental health contract.

Enter the provider number in columns b - r on row 5. Then using the dropdown menu in column A, indicate the funded program and amount funding such provider site.

	a	b	c	d	e	f	g	h	i
5	Provider Number Funded Program (Drop down)								
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									
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25									
26									
27									
28									
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32									
33									
34									
35									
36	Subtotal (DMH)								
37	Client, Third Party and Other Non-County Revenue								
38	Total by Provider Number								

REQUIRED FORMS - EXHIBIT 15
CalWORKs Mental Health Supportive Services
LEGAL ENTITY - CalWORKs PROVIDER BUDGET SUMMARY

Submission Date:	1/0/1900
County Fiscal Year:	0
Legal Entity Name:	
Legal Entity Number:	0

a	j	k	l	m	n	o	p	q	r	s
Provider Number / Funded Program (Drop down)										Funded Prog Total
Subtotal (DMH)										
Client, Third Party and Other Non-County Revenue										
Total by Provider Number										

REQUIRED FORMS - EXHIBIT 15

CalWORKs Mental Health Supportive Services

LEGAL ENTITY - CalWORKs PROVIDER MENTAL HEALTH SERVICES PLAN

1 Submission Date: 1/0/1900
2 County Fiscal Year(s): 0
3 Legal Entity Name: 0
4 Legal Entity Number: 0

5	a A. Legal Entity Level	b Mode	c Avg Cost per Client & per Unit	d Non-Medi-Cal/ Indigent[1]	e Row Percent	f Non-EPSDT MC[2]	g Row Percent	h MCE[3]	i Row Percent	j EPSDT MC[4]	k Row Percent	l MCHIP[5]	m Row Percent	n Total	o Row Percent
6	Unique Clients Served	05	#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
7	Units		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!	-	#DIV/0!
8	Dollars				#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!	-	#DIV/0!
9	Unique Clients Served	10	#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
10	Units		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!	-	#DIV/0!
11	Dollars				#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!	-	#DIV/0!
12	Unique Clients Served	15 (excl TBS)	#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
13	Units		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!	-	#DIV/0!
14	Dollars				#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!	-	#DIV/0!
15	Unique Clients Served	TBS	#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
16	Units		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!	-	#DIV/0!
17	Dollars				#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!	-	#DIV/0!

19	B. Provider Level	Srvc Area	Sup. District	Non- MC/ Indigent[1]	Row Percent	Non-EPSDT MC[2]	Row Percent	MCE[3]	Row Percent	EPSDT MC[4]	Row Percent	MCHIP[5]	Row Percent	Total	Row Percent
20	Provider No.				#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
21	Provider Site Name				#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!	-	#DIV/0!
22					#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!	-	#DIV/0!
23	Provider No.				#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
24	Provider Site Name				#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!	-	#DIV/0!
25					#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!	-	#DIV/0!
26	Provider No.				#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
27	Provider Site Name				#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!	-	#DIV/0!
28					#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!	-	#DIV/0!
29	Provider No.				#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
30	Provider Site Name				#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!	-	#DIV/0!
31					#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!	-	#DIV/0!
32	Provider No.				#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
33	Provider Site Name				#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!	-	#DIV/0!
34					#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!	-	#DIV/0!
35	Provider No.				#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
36	Provider Site Name				#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!	-	#DIV/0!
37					#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!	-	#DIV/0!
38	Provider No.				#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
39	Provider Site Name				#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!	-	#DIV/0!
40					#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!	-	#DIV/0!

Insert as many as needed

[1]Individuals who are not eligible for Short-Doyle/Medi-Cal, Medi-Cal Expansion, EPSDT or State Children's Health Insurance Program. [2]Beneficiaries eligible for Short Doyle/Medi-Cal program for certain individuals with low incomes and resources such as children and families, pregnant women, seniors, and persons with disabilities. [3]Beneficiaries eligible for Medi-Cal coverage expansion under the Affordable Care Act. [4]Beneficiaries eligible for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program. [5]Title XXI expanded Medicaid (Medi-Cal) Children's Health Insurance Program (includes Healthy Families transition to Medi-Cal clients/units).

REQUIRED FORMS - EXHIBIT 15
CalWORKs Mental Health Supportive Services
CalWORKs - SUBPROGRAM SCHEDULE

Contractor Name: 0 Subprogram Schedule: LE No.: 0
Agreement No.: Financial Summary: Fiscal Year:
Agreement Period: Amendment No.: Amendment Date:

A	B	C	D		E	F	G	H	I
		Non-Medi-Cal Funds			Medi-Cal (MC) Funds				
Rank	Subprograms	Direct/ Indirect Service	Manual Invoice	Non-MC Total (Gross Dollars)	EPSDT Medi-Cal	Non-EPSDT Medi-Cal	MCHIP	Medicaid Expansion	Medi-Cal Total (Gross Dollars)
	Categorically Funded Programs								
100N	Family Preservation Program			-					-
130N	Specialized Foster Care - DCFS MAT Non-Medi-Cal (Non-MC)			-					-
130.1M	Specialized Foster Care Enhanced MH Svcs Medi-Cal (MC)			-					-
130.2M	Specialized Foster Care MAT MC			-					-
130.4M	Specialized Foster Care TFC MC			-					-
130.3M	Specialized Foster Care Wraparound MC			-					-
300N	DCFS Medical Hub Non-MC			-					-
301M	DCFS PHF MC			-					-
302N	DCFS Independent Living Non-MC			-					-
304M	DCFS 2011 Realignment MC			-					-
131N,M	Group Home Aftercare Services			-					-
132N,M	First 5			-					-
140N	Comprehensive SOC Prog (SAMHSA,CFDA#93.958) Non-MC			-					-
142N	Family Wellness Network (SAMHSA,CFDA#93.243) Invoice			-					-
150N	Juvenile Justice Program (STOP) Non-MC			-					-
151N	Juvenile Justice Program (JJCPA-MHSAT) Non-MC			-					-
152N	Juvenile Justice Program (JJCPA - MST) Non-MC			-					-
153N	Juvenile Justice Program (COD) Non-MC			-					-
154N,M	Juvenile Justice Program (FFT)			-					-
326N,M	Juvenile Justice Program/Title IV-E MST			-					-
160N	PATH McKinney, CFDA #93.150 Non-MC			-					-
170N,M	Homeless Services			-					-
180N	CalWORKs MHS Non-MC			-					-
181N	CalWORKs Homeless Family Solutions System Services Non-MC			-					-
182N	GROW Non-MC			-					-
171N,M	Post-Release Community Supervision-Comm Reintegration			-					-
310N	DPH Dual Diagnosis Non-MC			-					-
330N	Other Employment Services/CCJCC Non-MC			-					-
350N	DCSS Forensic Center Services Invoice			-					-
	Federal/State Revenue								
360M	Federal/State Revenue MC			-					-
	CGF Funded Programs								
400N,M	DMH Mental Health Services (CGF)			-					-
190N,M	PES Relief Plan			-					-
340N,M	CGF IMD Step Down			-					-
	MHSA Funded Programs								
500N,M	MHSA Full Service Partnership (FSP) Child			-					-
	MHSA FSP TAY			-					-
	MHSA FSP Adult			-					-
	MHSA FSP Older Adult			-					-
501N	MHSA Family Support Services Non-MC			-					-
502M	MHSA Full Service Partnership Wraparound Child MC			-					-
	MHSA Full Service Partnership Wraparound TAY MC			-					-
510N,M	MHSA Field Capable Clinical Services (FCCS) Child			-					-
	MHSA FCCS TAY			-					-
	MHSA FCCS Adult			-					-
	MHSA FCCS Older Adult			-					-
	MHSA FCCS Service Extender Adult			-					-
	MHSA FCCS Service Extender Older Adult			-					-
520N,M	MHSA Wellness Center			-					-
530.1N,M	MHSA Enriched Residential Services			-					-
530.2N,M	MHSA Urgent Care Center			-					-
540N,M	MHSA IMD Step Down			-					-
800N	MHSA Probation Camp Program Non-MC			-					-
810N	MHSA Jail Transition & Linkage Invoice			-					-
820N	MHSA Planning, Outreach, & Engagement Non-MC			-					-
830N	MHSA Capital Facility Non-MC			-					-
600N,M	MHSA Prevention & Early Intervention (PEI) Child			-					-
	MHSA PEI TAY			-					-
	MHSA PEI Adult			-					-
	MHSA PEI Older Adult			-					-
	MHSA PEI Training			-					-
	MHSA PEI Technical Assistance			-					-
700.1N,M	MHSA Innovation IMHT			-					-
700.2N,M	MHSA Innovation ISM			-					-
700.3N,M	MHSA Innovation ICM			-					-
700.4N	MHSA Innovation IPRM Non-MC			-					-
	Subtotal	-	-	-	-	-	-	-	-
Maximum contract Amount									$ -

V8/11/14

REQUIRED FORMS – EXHIBIT 16

CalWORKs Mental Health Supportive Services

Supportive Services Staff Form

Name	Discipline	License (if applicable)	# of hours per week	Languages Spoken